COVID-19 Free-of-Charge Testing Encounter & Consent Form

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Last Name:	**First Name:**	**Middle Name:**	**Birth Date:** ____/____/____

Address: **(Not a PO Box)**	**Street:**_____ **City:**_____ **State:**_____ **Zip:**			
Home Phone:		**Cell Phone:**		**Gender:** ☐M ☐F
Race:	☐American Indian/Alaskan Native ☐Asian ☐Black or African American ☐Hawaiian Native or Other Pacific Islander ☐White ☐Not Stated			**Hispanic/Latino:** ☐Yes ☐No

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and other medical care providers of the Virginia Department of Health (VDH) to perform a COVID-19 test on me and/or my dependent, as named above. I understand that medical records will be retained for ten years after the date of the last visit, and in the case of a minor, the record will be retained for twenty-eight years after birth. Records will then be destroyed in a manner that assures confidentiality throughout the process and in its results.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.

Patient is a close contact to COVID-19 case for ≥15 minutes over 24 hours period ☐Yes ☐No

Symptomatic: ☐ Yes ☐ No **IF SYMPTOMATIC CHECK ALL THAT APPLY (Required for Antigen Testing)**

☐Cough (new onset or worsening of chronic cough)	☐Fever: Subjective *(felt feverish)* ***OR*** Temperature ≥100.4°F (38°C)
☐Chills or rigors	☐Headache
☐Muscle aches	☐Sore throat
☐Fatigue or malaise	☐Runny nose
☐Shortness of breath	☐Chest pain
☐Abdominal pain or tenderness	☐Nausea or vomiting
☐Diarrhea (3 or more loose stools/24-hr period)	☐Loss of appetite
☐Loss of taste/smell	☐Other:_____

X_____

Signature of Patient, Parent/Legal Guardian **Printed Name** **Date**

Relationship (If signature is not of Patient) _____

STAFF USE ONLY

X_____ **X**_____

Signature of Person Obtaining Consent (Required) **Signature of Witness (Needed for verbal consent only)**

PCR Testing			**Antigen/Point of Care Testing**
Lab Corp	**DCLS**	**UVA**	
☐L139900 ☐NP or ☐OP	☐87252 ☐NP or ☐OP	☐U0002 ☐NP or ☐OP	☐BinaxNOW **or** ☐Other_____ ☐Nasal Swab **or** ☐Other_____

CODING FOR CE		
Subprogram Code: OC	**Diagnosis Code:** Z1159 for Asymptomatic	**Diagnosis Code:** Z20828 for Contact with or Suspected Exposure

☐**Negative Result – No additional follow-up needed** ☐**Negative Result – Follow-up needed (see exception notes)**

☐**Positive Result – Follow-up needed (see exception notes)**